Nursing Commission
P.O. Box 47864
Olympia, WA 98504-7864
360.236.4700

Licensed Practical Nurse Activation by Endorsement Application Packet Contents:

Important Social Security Number Information:

Social Security Number: You are required by state and federal law to provide a social security number with your application. If you do not have a social security number at the time you send in this application, contact the Customer Service Center at 360.236.4700 for more information.

A U.S. Individual Taxpayer Identification Number (ITIN) or a Canadian Social Insurance Number (SIN) cannot be substituted.

In order to process your request:

Mail your application with your check or money order payable to:

Department of Health
PO Box 1099
Olympia, WA 98507-1099

Send additional documents to:

Nursing Commission
PO Box 47864
Olympia, WA 98504-7864

Contact us:

360.236.4700

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Washington State Department of Health
Nursing Commission
P.O. Box 1099
Olympia, WA 98507-1099
360.236.4700

Application Instructions Checklist

Important background check Information: Washington State law authorizes the Department of Health to obtain fingerprint-based background checks for licensing purposes. This check may be through the Washington State Patrol and the Federal Bureau of Investigation (FBI). This may be required if you have lived in another state or if you have a criminal record in Washington State. This would be at your own expense.

All information should be typed or printed clearly. It is your responsibility to submit the correct forms required.

☐ **Application Fee**. (This fee is non-refundable). You can check the **fee page** for current fees.

☐ **Step #1: Demographic Information:**

Social Security Number: You must list your social security number on your application. Please call the Customer Service Center at 360.236.4700 if you do not have one.

Legal Name: List your full name.

Definition of legal name: "Legal name" is the name appearing on your official certificate of birth or, if your name has changed since birth, on an official marriage certificate or an order by a court. The court must have the legal authority to change your name. We may ask you to prove your legal name. If you use any name other than your legal name on this application form, your application may be denied.

Birth date: Provide the city, state, and country where you were born.

Address: List the address we should use to send any information on your credential. Be sure to include the city, state, zip code, county and country. This will be your permanent address with Department of Health until we have been notified of a change.
See **WAC 246-12-310**.

Phone, Fax, and Cell Numbers: Enter your phone, fax, and cell numbers, if applicable.

Email: Enter your email address, if applicable.

Other Name(s): Indicate whether you are known or have been known under any other names. If you have a name change, you must notify the Department of Health in writing. You must include proof of this change. See **WAC 246-12-300**.

☐ **Step #2: Personal Data Questions:**
All applicants must answer the same personal data questions. They are focused on your fitness to practice the essential skills of this profession.

If you answer "yes" to any questions in this section, you must provide an appropriate explanation. You must also provide the documentation listed in the note after the question. If you do not provide this, your application is incomplete and it will not be considered.

- Question 5 includes misdemeanors, gross misdemeanors and felonies. You do not have to answer yes if you have been cited for traffic infractions. You can get copies of court records through the county courthouse where the conviction, plea, deferred sentence, or suspended sentence was entered.
- "Another jurisdiction" means any other country, state, federal territory, or military authority.

☐ **#3: Professional Education:**
Check next to high school diploma or GED. List in chronological order your educational preparation and post-graduate training. You must include the school you are currently attending if applicable. If you need more space, attach a separate piece of paper.

☐ **#4:License in Other State(s) or Country(ies)**
List all states/countries where you have held an RN or an LPN license. List these licenses in the order they were issued to you (1st, 2nd, 3rd, etc.)

☐ **#5: Other License:**
List all states where any health care licenses are or were held. Specifically list licenses granted as temporary, reciprocity, exemption or similar with type, date, grantor, and if license is current.

☐ **#6: AIDS Education and Training Attestation:**
AIDS affidavit must be initialed and dated. AIDS training may include self-study, direct patient care, courses, or formal training. This is required by **WAC 246-12-260** course content can be found in **WAC 246-12-270**.

☐ **#7: Applicant's Attestation:**
You must sign and date this for us to process the application. Read this very carefully.

Additional Information and Instructions

Note: If you attended a foreign school, use Foreign LPN Application Packet.

The following requirements must be met to complete license:

☐ **Current LPN License:** Enclose a copy of a **current/active** LPN license.

Military-trained LPNs: Washington State requires LPNs to have graduated from an approved nursing program. The only approved military LPN program accepted in Washington State is the Army LPN program through Fort Sam Houston, Texas (which is approved by the Texas Board). Evaluation by Washington State of the medic training (or equivalent) offered by the Navy, Army, and Air Force has determined that while these are intense and worthwhile programs, they are not equivalent to the requirements for practical nurse education. Graduates of these medic programs are not eligible for license as LPNs in Washington State even if already licensed in another state.

☐ Verification of LPN License from your **original U.S.** state of license. (form is enclosed) Call your state, they may charge a fee for this process. **Faxed verification will not be accepted under any circumstances.**

Special Note: NurSys is a new, National Verification System through the National Council of State Boards of Nursing. As yet not all states are on this new verification system. The National Council will do the verification of LPN and RN licenses for those states that are listed on the NurSys "form instructions." Please check this form to see if your **original** state of license is listed. If it is, please follow the instructions on this new form. If not, please follow the verification form we have sent you. When in doubt, call your original state of license. The telephone numbers are on the back of our verification form.

Please do not call about your application for the first three weeks after mailing. We are busy processing your application and calls will delay this processing.

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Washington State Department of Health
Nursing Commission
P.O. Box 47864
Olympia, WA 98504-7864
360.236.4700

Background Check Stamp Here

Date Stamp Here

Revenue 0258010000

Licensed Practical Nurse License Application

You must check the box next to Examination or Endorsement:

☐ Examination ☐ Endorsement

1. Demographic Information

Social Security Number (If you do not have a social security number, see instructions.)

— —

☐ Male
☐ Female

Name First Middle Last

Birth date (mm/dd/yyyy)

Place of birth: City | State | Country

Address

City | State | Zip | County

Country

Phone ( ) | Fax ( ) | Cell ( )

Email address

Mailing address (if different from above)

City | State | Zip | County

Country

NOTE: The mailing and email addresses you provide will be your addresses of record. It is your responsibility to maintain current contact information with the department.

Have you ever been known under any other name(s)? ☐ Yes ☐ No If yes, list name(s):

Will documents be received in another name? ☐ Yes ☐ No

If yes, list name(s):

For Office Use Only

☐ AIDS ☐ COC ☐ Verif (Foreign) ☐ Scripts ☐ CGFNS ☐ TOEFL
☐ Active License ☐ Other ☐ PDQ

☐ NCLEX Registration # _____

License Date _____ License # _____ Validation # _____
Graduation Date _____ School Code _____

2. Personal Data Questions

Yes No

1. Do you have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please attach explanation. ☐ ☐

"Medical Condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction, and alcoholism.

If you answered yes to question 1, explain:

1a. How your treatment has reduced or eliminated the limitations caused by your medical condition.

1b. How your field of practice, the setting or manner of practice has reduced or eliminated the limitations caused by your medical condition.

Note: If you answered "yes" to question 1, the licensing authority will assess the nature, severity, and the duration of the risks associated with the ongoing medical condition and the ongoing treatment to determine whether your license should be restricted, conditions imposed, or no license issued.

The licensing authority may require you to undergo one or more mental, physical or psychological examination(s). This would be at your own expense. By submitting this application, you give consent to such an examination(s). You also agree the examination report(s) may be provided to the licensing authority. You waive all claims based on confidentiality or privileged communication. If you do not submit to a required examination(s) or provide the report(s) to the licensing authority, your application may be denied.

2. Do you currently use chemical substance(s) in any way which impair or limit your ability to practice your profession with reasonable skill and safety? If yes, please explain. ☐ ☐

"Currently" means within the past two years.

"Chemical substances" include alcohol, drugs, or medications, whether taken legally or illegally.

3. Have you ever been diagnosed with, or treated for, pedophilia, exhibitionism, voyeurism or frotteurism? ☐ ☐

4. Are you currently engaged in the illegal use of controlled substances? ☐ ☐

"Currently" means within the past two years.

Illegal use of controlled substances is the use of controlled substances (e.g., heroin, cocaine) not obtained legally or taken according to the directions of a licensed health care practitioner.

Note: If you answer "yes" to any of the remaining questions, provide an explanation and certified copies of all judgments, decisions, orders, agreements and surrenders. The department does criminal background checks on all applicants.

5. Have you **ever** been convicted, entered a plea of guilty, no contest, or a similar plea, or had prosecution or a sentence deferred or suspended as an adult or juvenile in any state or jurisdiction? ☐ ☐

Note: If you answered "yes" to question 5, you must send certified copies of all court documents related to your criminal history with your application. If you do not provide the documents, your application is incomplete and will not be considered.

To protect the public, the department considers criminal history. A criminal history may not automatically bar you from obtaining a credential. However, failure to report criminal history may result in extra cost to you and the application may be delayed or denied.

2. Personal Data Questions (cont.)

Yes No

a. Are you now subject to criminal prosecution or pending charges of a crime in any state or jurisdiction ..... ☐ ☐

Note: If you answered "yes" to question 5a, you must explain the nature of the prosecution and/or charge(s). You must include the jurisdiction that is investigating and/or prosecuting the charges. This includes any city, county, state, federal or tribal jurisdiction. If charging documents have been filed with a court, you must provide certified copies of those documents. If you do not provide the documents, your application is incomplete and will not be considered.

b. If you answered "yes" to question 5a, do you wish to have decision on your application delayed until the prosecution and any appeals are complete? ..... ☐ ☐

6. Have you ever been found in any civil, administrative or criminal proceeding to have:
   a. Possessed, used, prescribed for use, or distributed controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes? ..... ☐ ☐
   b. Diverted controlled substances or legend drugs? ..... ☐ ☐
   c. Violated any drug law? ..... ☐ ☐
   d. Prescribed controlled substances for yourself? ..... ☐ ☐

7. Have you ever been found in any proceeding to have violated any state or federal law or rule regulating the practice of a health care profession? If "yes", please attach an explanation and provide copies of all judgments, decisions, and agreements? . ..... ☐ ☐

8. Have you ever had any license, certificate, registration or other privilege to practice a health care profession denied, revoked, suspended, or restricted by a state, federal, or foreign authority? ..... ☐ ☐

9. Have you ever surrendered a credential like those listed in number 8, in connection with or to avoid action by a state, federal, or foreign authority? ..... ☐ ☐

10. Have you ever been named in any civil suit or suffered any civil judgment for incompetence, negligence, or malpractice in connection with the practice of a health care profession? ..... ☐ ☐

3. Professional Education

High school graduate? ☐ Yes ☐ No

If no, GED? ☐ Yes ☐ No

Institute		Name/Location	Start Date	End Date	Diploma/Degree Granted
College	University				

4. License(s) in Other State(s) or Country(ies)

List all states/countries you have held an Registered Nurse license in. List these licenses in the order they were issued to you (1st, 2nd, 3rd, etc.)

Check One		State/Country	Current Expiration Date
As RN	As LPN		

State or **country** in which originally licensed by examination. _____

Year license first issued _____ as an ☐ RN ☐ LPN

Have you taken the State Board Test Pool Examination (SBTPE) or NCLEX in the United States? ☐ Yes ☐ No

If yes, state _____ as an ☐ RN ☐ LPN

Have you ever applied for license in Washington prior to this application? ☐ Yes ☐ No

If yes, under the name of_____ as an ☐ RN ☐ LPN Approximate date _____

5. Other License(s)

List all health care licenses held and in what state. Specifically list licenses granted as temporary, reciprocity, exemption or similar with type, date, grantor, and if license is current.

State	Profession	License Type	License		Method of License
			Year issued	Number	

6. AIDS Education and Training Attestation

I certify I have completed the minimum of seven (7) hours of education in the prevention, transmission and treatment of AIDS, including the topics of etiology and epidemiology, testing and counseling, infection control guidelines, clinical manifestations and treatment, legal and ethical issues confidentiality, psychosocial issues, and special population considerations. I understand I must maintain records documenting education for two (2) years and be prepared to submit those records to the department if requested. **I understand that if I provide any false information, my license may be denied, or if issued, suspended or revoked.**

Applicant's Initials	Date

7. Applicant's Attestation

I, _____ , declare under penalty of perjury under the laws of the state of
(Print applicant name clearly)
Washington that the following is true and correct:

- I am the person described and identified in this application.
- I have read **RCW 18.130.170** and **RCW 18.130.180** of the Uniform Disciplinary Act.
- I have answered all questions truthfully and completely.
- The documentation provided in support of my application is accurate to the best of my knowledge.

I understand the Department of Health may require more information before deciding on my application. The department may independently check conviction records with state or federal databases.

I authorize the release of any files or records the department requires to process this application. This includes information from all hospitals, educational or other organizations, my references, and past and present employers and business and professional associates. It also includes information from federal, state, local or foreign government agencies.

I understand that I must inform the department of any past, current or future criminal charges or convictions. I will also inform the department of any physical or mental conditions that jeopardize my ability to provide quality health care. If requested, I will authorize my health providers to release to the department information on my health, including mental health and any substance abuse treatment.

Dated _____in _____ (city, state)

By:_____
Signature of applicant

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NCSBN Nursys®
National Council of State Boards of Nursing

FORM INSTRUCTIONS

1. Only boards of nursing within the United States have access to Nursys.® If you need verification of a license for a foreign country or to an agency other than a state board of nursing, please contact your state board of nursing.
2. You **MUST CONTACT** the state where you are seeking licensure to determine which state(s) they require verification from, as boards of nursing have different requirements.

   If you do not need verification of a license from one of the states listed below, **DO NOT** complete this form. Instead, follow the verification instructions of the state where you are seeking licensure. Complete this form **ONLY** if the state where you are seeking licensure requires verification from one of the states listed below.

Alaska (AK)	Kentucky (KY)	New Hampshire (NH)	South Dakota (SD)
Arizona (AZ)	Maine (ME)	New Jersey (NJ)	Tennessee (TN)
Arkansas (AR)	Maryland (MD)	New Mexico (NM)	Texas (TX)
Colorado (CO)	Massachusetts (MA)	North Carolina (NC)	Utah (UT)
Delaware (DE)	Minnesota (MN)	North Dakota (ND)	Vermont (VT)
Florida (FL)	Mississippi (MS)	Ohio (OH)	Virginia (VA)
Idaho (ID)	Missouri (MO)	Oregon (OR)	West Virginia-PN (WV)
Indiana (IN)	Montana (MT)	South Carolina (SC)	Wisconsin (WI)
Iowa (IA)	Nebraska (NE)		

3. Please complete all sections of this form. Forms with missing information or incorrect payments will be returned. **SEND ONLY THIS FORM AND PAYMENT. ALL OTHER FORMS ARE UNACCEPTABLE**.
4. **PAYMENT:** To verify RN licenses, the total fee is $30, regardless of how many states you are licensed in or how many states you are applying to. To verify LPN licenses, the total fee is $30, regardless of how many states you are licensed in or how many states you are applying to. To verify both RN and LPN licenses, the total fee is $60, regardless of how many states you are licensed in or how many states you are applying to.

   All payments must be guaranteed funds. **The only acceptable forms of payment are: certified checks, cashiers checks, or money orders** – made payable to the **NCSBN**. DO NOT SEND cash, personal checks, business checks, credit cards, or traveler's checks. **Fees are non-refundable**.
5. Please complete this form in blue or black ink. Print or type clearly. Illegible forms will be returned.
6. Verifications are entered into Nursys® in the order in which they are received at NCSBN. **The verification report will remain in Nursys® for 90 days, after which it expires.** When the Board of Nursing receives your Endorsement Application, the board will access Nursys® to verify any licenses held in the states listed in number 2 above. No paper reports are sent from NCSBN.
7. **EXPIRED REPORTS:** If your verification has expired, you must pay an additional $30 and submit a new verification request form to NCSBN.
8. Nursys® information is updated monthly from the participating nursing boards listed in number 2 above. A nurse who recently received a license may have to wait until the next update before the information is available in Nursys® for license verification.
9. If you have questions regarding this form, please contact the Nursys® License Verification Department at (312) 525-3780 or toll free (866) 819-1700.

*** **NEW** *** Want to process your verification faster? Try our new secure Online Verification to process your verification immediately. Go to **https:\\www.nursys.com**

LICENSE VERIFICATION REQUEST FORM

***** NEW ***** Want to process your verification faster? Try our new secure Online Verification to process your verification immediately. Go to **https:\\www.nursys.com**

Please use blue or black ink. ***See reverse side for form eligibility and instructions.***

PERSONAL INFORMATION

Social Security Number:	Date of Birth (mm/dd/yyyy)	
First Name:	Middle Name:	Last Name:
Maiden Name:	Date of Original License (mm/yyyy)	
Street Address:		
City:	State:	Zip/Postal Code:
Country:	Home Phone:	Work Phone:

ENDORSEMENT INFORMATION *List the license types that you need verified*

License Type (check one)	Total Verification Fee
LPN: ☐	$30.00
RN: ☐	$30.00
Both LPN & RN: ☐	$60.00

Fees are not refundable

The only acceptable forms of payment are
CERTIFIED CHECK, CASHIER'S CHECK,
or **MONEY ORDER**.
Made payable to: NCSBN
DO NOT SEND cash, personal checks, business checks, or travelers checks.

LICENSE INFORMATION *List all licenses that you have ever had*

	Jurisdiction/State	RN License Number	PN License Number
Original			
Additional			
Additional			
Additional			

State applying to: _____

_____

I, the above named individual, hereby apply for verification to the National Council of State Boards of Nursing to permit the NCSBN and/or its Member Boards to verify my license, educational, disciplinary, and related information in Nur*sys*® for the purposes of supporting my request for endorsement verification in the jurisdiction(s) listed above and any other states in which I have ever been licensed. I also confirm that the information I have submitted is true.

My application fee of **$** _____ in **guaranteed funds** is attached.

Mail this form to:
National Council of State Boards of Nursing, Inc.
35331 Eagle Way
Chicago, IL 60678-1353
DO NOT SEND THIS FORM TO YOUR BOARD OF NURSING

Signature _____ Date _____

Washington State Department of Health
Nursing Commission
P.O. Box 47864
Olympia, WA 98504-7864
360.236.4700

License Verification

Please complete the top portion of this form and forward to your **original** state of license.
(Please contact your original state of license for fee charged and processing time.)

Check One Box: ☐ **Registered Nurse** ☐ **Licensed Practical Nurse**

Name Last	First	Middle Initial
Social Security Number (If you do not have a social security number, see instructions.) — —		Previous Last Names Used
Address		
City	State / Zip	County
Name as it appears on original license	Original State of License	Current State of License

I hereby authorize the release of my license data to the Washington State Nursing Commission.

Signature _____ Date _____

This portion to be completed by original state of license and mailed to: Washington State Nursing Commission, P.O. Box 47864, Olympia, Washington 98504-7864.

This is to certify that _____ was issued license number _____

on _____ to practice ☐ registered nursing ☐ licensed practical nursing (vocational nursing).

Licensed by: ☐ Exam ☐ Endorsement ☐ Other (specify)

Current License Status: ☐ Active ☐ Inactive ☐ Lapsed

Has this license ever been encumbered (denied, revoked, suspended, surrendered, limited, placed on probation)? ☐ Yes ☐ No (if yes, attach explanation)

Disciplinary action pending? ☐ Yes ☐ No (if yes, attach explanation)

Nursing Education Program Completed:

Location (City & State):

Type of Nursing Program: ☐ Diploma ☐ BSN ☐ ADN ☐ LPN ☐ Other (specify) | Date of Completion

Examination Scores: State Board Test Pool Exam

	Score	Series
Medical		
Psychiatric		
Obstetric		
Surgical		
Nursing of Child		
LPN/VN		

NCLEX:

RN _____ Series _____

LPN _____ Series _____

NCLEX CAT:

RN _____ Date _____

LPN _____ Date _____

Signature _____ State _____ Date _____

State Boards of Nursing

Alabama	334-242-4060
Alaska	907-269-8161
Arizona	602-889-5150
Arkansas	501-686-2700
California	916-322-3350
California (LPN)	916-263-7800
Colorado	303-894-2430
Connecticut	860-509-7624
Delaware	302-739-4522
District of Columbia	202-724-4900
Florida	904-858-6940
Georgia	912-207-1640
Hawaii	808-586-3000
Idaho	208-334-3110
Illinois	312-814-2715
Indiana	317-232-2960
Iowa	515-281-3255
Kansas	785-296-4929
Kentucky	502-329-7000
Louisiana	504-838-5332
Maine	207-287-1133
Maryland	410-585-1900
Massachusetts	617-727-1631
Michigan	517-335-0918
Minnesota	612-617-2270
Mississippi	601-987-4188
Missouri	573-751-0681
Montana	406-444-2071
Nebraska	402-471-4376
Nevada (Reno)	702-786-3135
Nevada (Las Vegas)	702-739-5968
New Hampshire	603-271-2323
New Jersey	973-504-6586
New Mexico	505-841-8340
New York	518-474-3845
North Carolina	919-782-3211
North Dakota	701-328-9777
Ohio	614-466-3947
Oklahoma	405-962-1800
Oregon	503-731-4745
Pennsylvania	717-783-7142
Rhode Island	401-222-2827
South Carolina	803-896-4550
South Dakota	605-362-2760
Tennessee	615-532-5166
Texas	512-305-7400
Utah	801-530-6628
Vermont	802-828-2396
Virginia	804-662-9909
West Virginia	304-558-3572
Wisconsin	608-266-2112
Wyoming	307-777-7601

Nursing Commission
P.O. Box 1099
Olympia, WA 98504-1099
360.236.4700

Health Professions Reference Numbers and Links

RCW/WAC Links

UDA RCW 18.130 ..... Uniform Disciplinary Act

APA RCW 34.05 ..... Administrative Procedure Act

WAC 246-12 ..... Administrative procedures and requirements

RCW 18.79 ..... Licensed Practical Nursing Law

RCW 18.130.170 ..... Capacity of license holder to practice—hearing—Mental or physical examination—Implied Consent

RCW 18.130.180 ..... Unprofessional Conduct

WAC 246-840 ..... Licensed Practical Nursing Rules

WAC 246-840-090 ..... License by interstate endorsement

WAC 246-840-990 ..... Fees

WAC 246-12-020 ..... How to obtain initial credential

WAC 246-12-300 ..... Name changes

WAC 246-12-310 ..... Address changes

Online

AIDS Training ..... http://www.doh.wa.gov/cfh/hiv_aids/Prev_Edu/license_training.htm

Nursing Commission https://fortress.wa.gov/doh/hpqa1/hps6/Nursing/default.htm

Required Hours of Training, WAC 246-840-360

Continuing education (CE) Training after license has been issued ..... 30 hours /every two years

Pharmacotherapeutics related to licensee's scope of practice is required if you have prescriptive authority ..... 15 hours